Colorado Department of Public Health and Environment
Office of Emergency Preparedness and Response
Nine Regional Healthcare Coalition Guidance Document
3/9/2017

DOCUMENT PURPOSE: This document is provided by the Colorado Department of Public Health and Environment Office of Emergency Preparedness and Response (CDPHE_OEPR) to establish the Colorado Regional Healthcare Coalition (HCC) collaborative network of healthcare organizations and their respective public and private sector response partners who will serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities for healthcare organizations.

To advance all-hazards preparedness and national health security, promote responsible stewardship of Federal funds, and reduce burden, Assistant Secretary for Preparedness and Response (ASPR) and Centers for Disease Control and Prevention (CDC) have aligned ASPR's Hospital Preparedness Program (HPP) and the CDC's Public Health Emergency Preparedness (PHEP) grants. The aligned program serves as an opportunity to continue coordinated preparedness efforts between healthcare and public health through healthcare coalitions, originally initiated in previous grant cycles. The development and integration of reporting for Healthcare Coalitions is a key requirement in the new five-year HPP-PHEP grant program.

The CDPHE_OEPR program is aligned with the Colorado Nine All-Hazard Regions. As such, extensive improvements in regional-based public health and medical preparedness, planning, and response coordination has been made over the past 15 years in Colorado. For the most part, the natural patient catchment areas are contained within the regional boundaries; however, patient referral routes in Colorado largely, radiate from all parts of the state to the Denver metropolitan area, making HCC border alignment by patient referral patterns extremely difficult. Therefore, to ensure continuity of effort, planning efficiencies, and coordinated response efforts, Colorado is using the existing nine All Hazard Emergency Management Regions to form the basis of the Colorado HCC Regions. Some of the Nine HCC Regions may further divided into sub-committees or sub-HCCs to account for excessive size and/or geographical features (such as mountain ranges), unique challenges (multi-national tourism destinations), or large concentrations of population/partner organizations). Each of Colorado's Nine Regional HCCs will have participation by a minimum of two acute care hospitals, Emergency Medical Services (EMS), public health agencies, and emergency management authorities. Each of these Nine Regional HCCs will have the common purpose to serve as a collaborative network of healthcare organizations (HCOs) to support healthcare preparedness, response, recovery, and mitigation activities.

Definition of Healthcare Coalition (HCC)

The HPP-PHEP grant guidance defines Healthcare Coalitions (HCCs) as a sub-state regional healthcare system of emergency preparedness activities involving member organizations. Colorado further defines HCCs as a collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to support healthcare related preparedness, response, recovery, and mitigation activities. In Colorado, each Regional HCC must consist of a minimum of four contiguous counties; have a core membership of at least two Hospitals, EMS Agencies, Emergency Management Organizations, and Local Public Health Agencies; and have of multiple coordinating partner organizations.

Purpose of a Healthcare Coalition

HCCs are the primary method to prepare for and provide support, when activated as part of the Emergency Support Function 8 (ESF 8) system, for incidents among diverse HCOs within a geographic region. Tiered, scalable, and flexible coordination among varied HCOs will facilitate more effective, efficient, and timely situational awareness and coordination of resources, among the HCC's HCOs, resulting in an overall improved healthcare emergency response.

Role of HCCs

The role of HCCs is to communicate and coordinate. HCCs should not replace or interfere with official command and control structures authorized by state and local authorities and emergency management. Through effective planning integration, each HCC aspires to be recognized by its regional partners as having a formally defined and exercised role that is utilized under ESF 8 during incident response and integrated into local, regional, and state emergency operations plans to facilitate the communication and coordination of HCO response during disasters.

HCC Response/Operational Role

HCCs should support ESF 8 authorities by providing multi-healthcare agency coordination in order to provide advice on decisions made by incident management regarding information and resource coordination for healthcare organizations. This includes either a response support role as part of a multi-agency coordination group to assist incident management (area command or unified command) with decisions, or through coordinated plans to guide decisions regarding HCO support.

Who Should Be Members of an HCC

According to the 2017-2022 Health Care Preparedness and Response Capabilities guide produced by the Office of the Assistant Secretary for Preparedness and Response, HCCs should include a diverse membership to ensure a successful whole community response. If segments of the community are unprepared or not engaged, there is a greater risk that the health care delivery system will be overwhelmed. As such, the HCC should liaise with the broader response community on a regular basis

Core HCC members include, at a minimum, the following:

- 2 Hospitals
- EMS (including inter-facility and other non-EMS patient transport systems)
- Emergency management organizations
- Public health agencies

Additional HCC members may include but are not limited to the following:

- Behavioral health services and organizations
- Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)
- Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks
- Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indian Health Service facilities, military treatment facilities)
- Home health agencies (including home and community-based services)
- Infrastructure companies (e.g., utility and communication companies)
- Jurisdictional partners, including cities, counties, and tribes
- Local chapters of health care professional organizations (e.g., medical society, professional society, hospital association)
- Local public safety agencies (e.g., law enforcement and fire services)
- Medical and device manufacturers and distributors
- Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)

- Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers (FQHCs), Colorado Rural Health Clinics, urgent care centers, freestanding emergency rooms, stand-alone surgery centers)
- Primary care providers, including pediatric and women's health care providers
- Schools and universities, including academic medical centers
- Skilled nursing, nursing, and long-term care facilities
- Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
- Other (e.g., child care services, dental clinics, social work services, faith-based organizations)

Specialty patient referral centers (e.g., pediatric, burn, trauma, and psychiatric centers) should ideally be HCC members within their geographic boundaries. They may also serve as referral centers to other HCCs where that specialty care does not exist. In such cases, referral centers' support of HCC planning, exercises, and response activities can be mutually beneficial.

Urban and rural HCCs may have different membership compositions based on population characteristics, geography, and types of hazards. For example, in rural and frontier areas—where the distance between hospitals may exceed 50 miles and where the next closest hospitals are also critical access hospitals with limited services—FQHCs, Rural Health Clinics, tribal health centers, referral centers, or support services may play a more prominent role in the HCC.

An HCC IS…

- A regional healthcare multi-agency coordinating group that includes multiple healthcare organization members (HCOs) within the response community
- A collective team that supports the planning and preparedness efforts in coordination with Emergency Management and other Emergency Support Function (ESF) 8 (health and medical) partners
- A collective team that supports disaster operations through information sharing, assessing local resources, and situational awareness
- A collaborative effort to plan, organize, equip, train, exercise, evaluate and outline corrective actions

An HCC IS NOT…

- One individual agency/organization or county
- Two individual agencies/organizations
- Hospital-only regional group
- Public health-only regional group
- A deployable response team
- Made up primarily of individual organizations

An HCC DOES…

- Focus on the cycle of preparedness, response, recovery, and mitigation
- Promote information sharing among HCOs
- Promote situational awareness for HCOs
- Conduct regional healthcare coalition meetings
- Engage partners in regional (joint) Hazard Vulnerability Assessment (HVA) discussions
- Participate in at least one regional-level exercise over the five year grant period that tests performance measures
- Have the ability to share Essential Elements of Information (EEI) data electronically across the HCC (e.g., bed status)

- Utilize subject matter experts from across the region for information sharing

An HCC DOES NOT…

- Conduct non-preparedness or non-response related activities or business
- "Command" the actions of Coalition members or any other response entities it might interact with during an emergency
- Use only one county-level Hazard Vulnerability Assessment (HVA) for substitution of the entire regional HVA
- Have to own the electronic systems being shared or utilized within the region
- Have to have the resources locally, but have access to resources within the region

The Value of Participating in an HCC – It isn't about the money

In the past, Colorado funded Hospitals, Behavioral Health, and Medical Reserve Corps directly with funds from the HPP grant. This direct funding allowed CDPHE to pinpoint funding directly to those entities and rapidly build capability, establish equipment and supply caches, and lay the foundation for those partners to plan and prepare for incidents that would potentially adversely impact the community's ability to respond to and recover from incidents. Now, the focus has shifted from building capability (purchasing equipment/supplies) for the hospitals, to building a planning and response capability that reaches beyond the doors of the hospital and into the community. By continuing to be an essential part of the HCC, Hospitals, Behavioral Health providers, and Medical Reserve Corps organizations, will be able to help guide other organizations to be better prepared in the future while continuing to improve their own preparedness programs with the help, support, and funding provided by the HCC.

According to direction provided by ASPR, HCCs are groups of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies, etc.) in a defined geographic location that play a critical role in developing health care delivery system preparedness and response capabilities. HCCs serve as multiagency coordination groups that support and integrate with ESF 8 activities in the context of incident command system (ICS) responsibilities. HCCs coordinate select and appropriate activities among HCOs and other stakeholders in their communities; these entities comprise HCC members that actively contribute to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained health care personnel.

The value of participating in an HCC is not limited to emergency preparedness and response. Day-to-day benefits may include:

- Meeting regulatory and accreditation requirements
- Enhancing purchasing power (e.g., bulk purchasing agreements)
- Accessing clinical and non-clinical expertise
- Networking among peers
- Sharing leading practices
- Developing interdependent relationships
- Reducing risk
- Addressing other community needs, including meeting requirements for tax exemption through community benefit

HCC REGIONAL BOUNDARIES/SUBCOMMITTEES/Sub-HCCs

While the Nine Regional HCC model will provide a solid structure for the HCC program in Colorado, there are some regions that may wish to establish subcommittees along geographic lines or maintain sub-HCCs. A primary concern for a

Regional HCC maintaining subcommittees, especially sub-HCCs is that **Regional HCCs cannot abdicate responsibility for completing grant deliverables to sub-committees or sub coalitions**. Regional HCC subcommittees are intended to encourage planning, training, and exercising along functional lines by aligning "like" organizations within the region. However, it is understood that some of the preexisting HCCs have very strong organizational ties and history and can provide a strong backbone for the Regional HCCs. In addition to subcommittees aligned by "like" organizations and sub-HCCs with pre-existing strong HCCs, the Regional HCCs should also consider geographic boundaries, physical impediments (mountains/distance), as well as the number and type of potential member organizations when determining if they should have subcommittees within the region. Other factors that may be considered are local government policy and the independent nature of Colorado's counties based upon the historical nature of being a Home Rule State; political tensions that exist between some communities; community ability to meet contractual obligations; integrated healthcare system relationships; and patient referral patterns. The critical point to consider is that there is often no one controlling factor for determining if Regional HCCs should create subcommittees. The most important consideration is to have the greatest effect on each regional HCC's ability to effectively plan, coordinate, and integrate into the existing response network during emergency situations.

Colorado's Nine Regional Healthcare Coalitions: (see HCC appendices for further details)

1. **North Central Region HCC (Name TBD):**

   Tri-County HCC. Consisting of Adams, Arapahoe, Douglas, and Elbert Counties

   Metro Foothills HCC. Consisting of Clear Creek, Denver, Gilpin and Jefferson Counties

   HAMR HCC. Consisting of Boulder and Broomfield Counties

2. **Northeast Region HCC (Name TBD):**

   Consisting of Cheyenne, Kit Carson, Larimer, Lincoln, Logan, Morgan, Philips, Sedgwick, Washington, Weld, and Yuma Counties

3. **Northwest Region HCC (Name TBD):**

   Consisting of Eagle, Garfield, Grand, Jackson, Mesa, Moffat, Pitkin, Rio Blanco, Routt, and Summit Counties

4. **West Region HCC**

   Consisting of Delta, Gunnison, Hinsdale, Montrose, Ouray, and San Miguel Counties

5. **Southwest Region HCC (Name TBD):**

   Consisting of Archuleta, Dolores, La Plata, Montezuma, and San Juan Counties and the Mountain Ute and Southern Ute Indian Tribal Nations

6. **San Luis Valley Region HCC (Name TBD):**

   Consisting of Alamosa, Costilla, Conejos, Mineral, Rio Grande, and Saguache Counties

7. **South Region HCC (Name TBD):**

   Consisting of Custer, Fremont, Huerfano, Las Animas, and Pueblo Counties

8. **Southeast Region HCC (Name TBD):**

   Consisting of Baca, Bent, Crowley, Kiowa, Otero, and Prowers Counties

9. **South Central Region HCC:**

Consisting of Chaffee, El Paso, Lake, Park, and Teller Counties

Governance

Each of Colorado's Nine Regional HCC's are required to establish a governing body and structure to identify how the HCC conducts activities related to health care delivery system readiness coordination. The HCC governance body must be adopted by its members, reviewed regularly, and include a process for making changes. The governance body should:

- Represent HCC membership
- Establish an organizational structure that includes executive and general committees, election or appointment processes, and any necessary administrative rules and operational functions (e.g., bylaws) to support HCC activities
- Define member guidelines for participation and engagement that consider each member and region's geography, resources, and other factors
- Develop a governance document that defines HCC integration within existing local, state, and member-specific incident management structures and specifies roles—such as a primary point of contact (POC)—that serve as the liaison to ESF 8 and Emergency Operations Centers (EOCs) during an emergency
- To plan for the longevity and sustainability of the Regional HCCs, it is recommended HCCs consider establishing an independent non-profit corporation and eventually apply for IRS 501C3 status
    - As a non-profit entity, HCCs would be able to own equipment and supplies, hire staff (provided they obtain a Federal Employer Identification Number (FEIN), and act as their own fiscal agent
    - Without establishing a non-profit corporation, HCCs will be required to retain the services of a fiduciary agent such as a governmental agency, a nonprofit hospital, or other nonprofit/non-governmental organization that has the ability to contract with the State to hold the HCCs assets (grant funds) and/or own physical items such as supplies and equipment

Fiscal Responsibility

Colorado provides the Nine Regional HCC's the flexibility to establish their own process to contract with and receive funds from CDPHE. The HCC's options include:

- Establishing as a Non-Profit Corporation in accordance with the Laws of the State of Colorado and implementing the accounting, controls, and procurement processes necessary to satisfy State auditing and funds control processes.
- Contract with an outside Non-Profit Corporation to act as the HCC's fiscal agents to manage coalition funds, procurement, and contracting efforts in accordance with State auditing and funds control processes.
- Have an HCC member Governmental Agency act as the HCC's fiscal agent. *Other member agencies may be fiscal agents if allowed by State procurement rules.*

ALTERNATIVE SOLUTION:

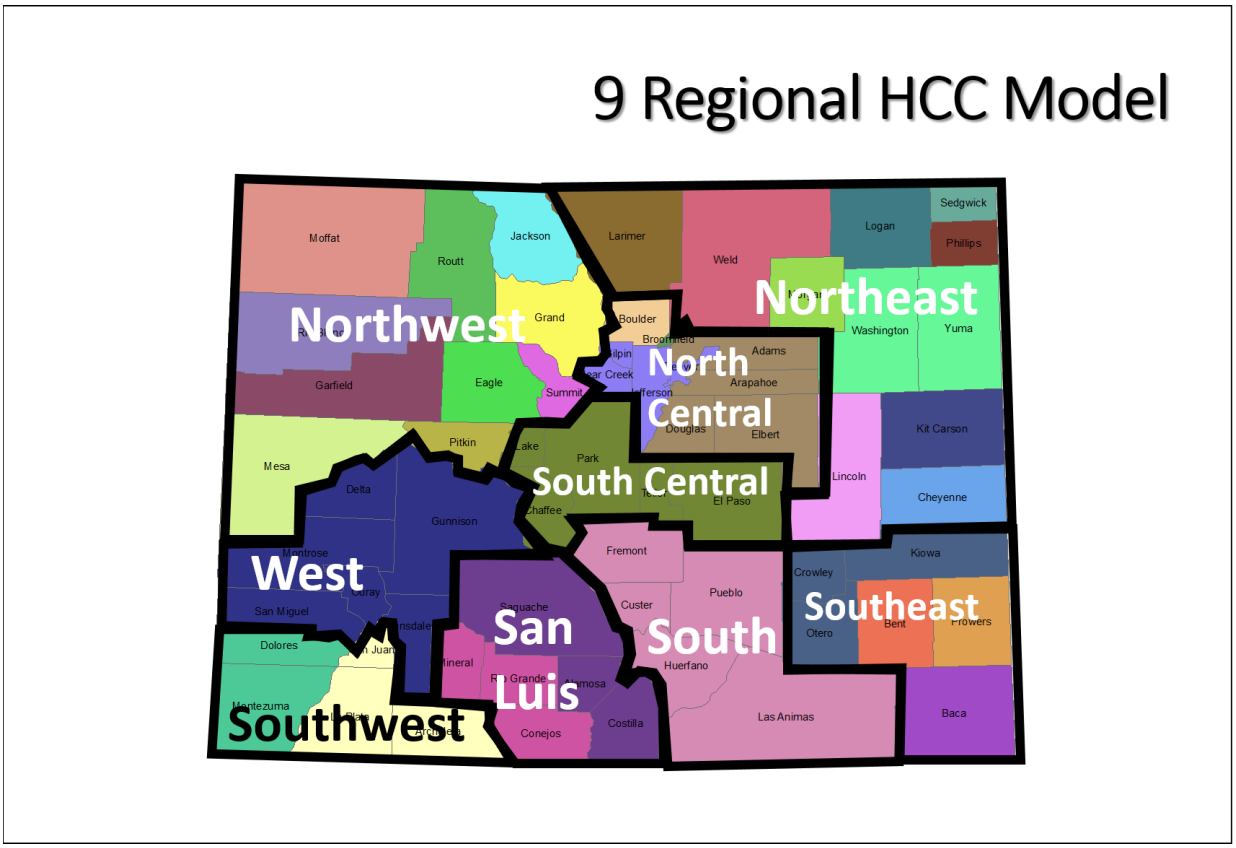
In an effort to reduce overall expenditures by having multiple Fiscal Agents, CDPHE_OEPR is willing to contract with a designated fiscal agent to represent all of the Nine Colorado Regional HCCs agreeing to be included.

Regional HCC Funding

Funding from ASPR, received by CDPHE_OEPR, designated to support HCCs will be provided to each of the designated fiscal agents to reimburse HCCs for expenses associated with meeting grant deliverables. CDPHE_OEPR will provide HCCs an accounting of funds received from ASPR showing the total amount received; the state indirect and the total amounts OEPR retains for administrative expenses, centrally procured services (such as-but not limited to, EMSystems; Colorado Volunteer Management system; and Colorado Hospital Association and Colorado Community Health Network

services); and the amounts allocated to each of the Nine Regional HCCs. Appendices "A-I" provide estimates of HCC funding for the 2017-2018 budget year. The figures provided for each HCC are only estimates and are subject to the availability of funds, negotiation of centrally procured services, and the application of the state indirect rate. Actual funding amounts will be provided to the HCCs when a notice of award is received for this grant opportunity.

Funding is subject to annual appropriations and availability. Funding allocation from the CDPHE_OEPR to the HCCs will be based on a combination of a base amount of $75,000 per Regional HCC; plus, a regional impact amount calculated at $5,000 per hospital (as identified by CDPHE Health Facilities) in each HCC region; plus a region size impact rate based on the square miles in each HCC multiplied by the standard state travel rate of $0.49 per mile; as well as a travel expense factor for travel from the farthest edge of each of the Regional HCCs to Denver for two meetings (lodging rates were included for those regions beyond a three hour drive from Denver). The remaining available funds are allocated to a population impact amount based upon the percentage of the overall state population the region serves. HCCs are NOT required to use this funding formula to distribute funds to individual coalition members. The hospital and travel impact calculations do not determine how much money each coalition has available to provide to hospitals or use for travel expenses. Determining how HCCs allocate funding should be based upon the HCC Governing body's determination as to the most efficient and effective method of meeting grant deliverable requirements. The determination of how to allocate funds within each of the HCCs will be determined by each of the Nine Regional HCC's governing bodies.



Additional information, resources, and frequently asked questions are available on the CDPHE website: https://www.colorado.gov/pacific/cdphe/health-care-coalitions

Resources are also available on the ASPR TRACIE Healthcare Emergency Preparedness Information Gateway: https://asprtracie.hhs.gov/

The Coloardo NonProfit Association may be a good source of information to HCCs wishing to establish as non-profit organizations: https://www.coloradononprofits.org/knowledge/faq/how-do-i-start-nonprofit-organization

The Colorado Secretary of State Office is the official source for information on establishing non-profit organizations: https://www.sos.state.co.us/

Appendix A:
North Central Region (Name TBD) Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Adams:	490,829	1,167.65	4
▪ Arapahoe:	630,564	798.10	3
▪ Boulder:	319,177	726.29	4
▪ Broomfield:	64,788	33.03	1
▪ Clear Creek:	9,328	395.23	0
▪ Denver:	683,096	153.00	6
▪ Douglas:	322,017	840.25	3
▪ Elbert:	24,694	1,850.85	0
▪ Gilpin:	5,819	149.90	0
▪ Jefferson:	565,230	764.21	3
Total:	3,115,542	6,878.51	24

- Population density (Average number of people per square mile): 453
- Hospital density (Average number of people per hospital): 129,814
- Hospital density (Average square miles served per hospital): 287

Boundary Justification:

- This existing HCC is a strong multi-jurisdiction program that meets all of the requirements for Core membership and has numerous like partners to contribute to planning, mutual support, and a robust response support to ESF 8 authorities.
- Largely a metropolitan area HCC that serves a dense population.
- Large number of partner organizations necessitate a robust organizational structure for the regional HCC with sub-region HCCs working together.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	-	140,230
OEPR Administration: (15% ASPR Cap)	-	467,909
		608,139
Funds to support HCCs:		2,511,253

Less Centrally Procured Services:		
CHA:		-321,000 (2016-17 amount)
CCHN:		-170,000 (2016-17 amount)
EM Systems:		-443,000 (2016-17 amount)
CVM:		-102,000 (2016-17 amount)
		1,036,000
Cash available to support HCCs:		1,475,253

North Central Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	123,656
Population Impact: 57.10%	193,930
Total:	**$392,586**

Appendix B:
Northeast Region (TBD) HEALTHCARE COALITION

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Cheyenne:	1,846	1,778.28	1
▪ Kit Carson:	8,239	2,160.82	1
▪ Larimer:	322,832	2,596.00	5
▪ Lincoln:	5,549	2,577.63	1
▪ Logan:	22,112	1,838.55	1
▪ Morgan:	28,275	1,280.43	2
▪ Phillips:	4,331	687.93	2
▪ Sedgwick:	2,376	548.04	1
▪ Washington:	4,839	2,518.03	0
▪ Weld:	284,876	3,987.24	1
▪ Yuma:	10,125	2,364.41	2
Total:	705,400	22,337.36	17

- Population density (Average number of people per square mile): 32
- Hospital density (Average number of people per hospital): 41,494
- Hospital density (Average square miles served per hospital): 1,314

Boundary Justification:

- This new regional HCC will combine 11 counties that had previously been mostly all stand-alone HCCs.
- These counties share a wide mixture of unique challenges from supporting large metropolitan communities with college campuses, having significant oil/gas production industry, to having large rural/frontier agricultural areas.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

Northeast Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	97,601
Population Impact: 12.93%	43,908
Total:	**$216,510**

Appendix C:
Northwest Region (TBD) Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Eagle:	53,580	1,684.53	1
▪ Garfield:	58,082	2,947.56	2
▪ Grand:	14,615	1,846.33	2
▪ Jackson:	1,352	1,613.72	0
▪ Mesa:	149,249	3,328.97	3
▪ Moffat:	12,923	4,743.29	1
▪ Pitkin:	17,845	970.70	1
▪ Rio Blanco:	6,459	3,220.93	2
▪ Routt:	24,103	2,362.03	1
▪ Summit:	30,299	608.36	1
Total:	368,507	23,326.42	14

- Population density (Average number of people per square mile): 16
- Hospital density (Average number of people per hospital): 28,347
- Hospital density (Average square miles served per hospital): 1,794

Boundary Justification:

- This new HCC brings together 10 individual county-based HCCs.
- These counties encompass a fairly large portion of land area in western Colorado and share a mixture of rural/frontier ranching communities, mountainous terrain, and home to the majority of the ski resorts in Colorado.
- These counties and have a unique mix of extensive mountainous terrain, wide open spaces, oil/gas industry, and extensive recreational tourism.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

Northwest Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	83,415
Population Impact: 11.25%	22,938
Total:	**$181,353**

Appendix D:
West Region Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Delta:	29,950	1,142.05	1
▪ Gunnison:	16,145	3,239.10	1
▪ Hinsdale:	767	1,117.25	0
▪ Montrose:	40,911	2,240.70	1
▪ Ouray:	4,658	541.59	0
▪ San Miguel:	7,859	1,286.61	0
Total:	100,290	9,567.30	3

- Population density (Average number of people per square mile): 10
- Hospital density (Average number of people per hospital): 33,430
- Hospital density (Average square miles served per hospital): 3,189

Boundary Justification:

- This existing HCC has been working and planning together for years and will continue to work together to ensure the west region is prepared to respond when called upon.
- One of the challenges of this community is the flow of passengers through the Montrose County airport with many flights originating outside the United States.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

West Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	21,932
Population Impact: 1.84%	6,243
Total:	**$103,175**

Appendix E:
Southwest Region (TBD) Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Archuleta:	12,384	1,350.18	1
▪ Dolores:	1,953	1,067.05	0
▪ LaPlata:	54,907	1,692.08	2
▪ Montezuma:	23,139	2,029.53	1
▪ San Juan:	705	387.49	0
Total:	96,088	6,526.33	4

- Population density (Average number of people per square mile): 15
- Hospital density (Average number of people per hospital): 24,022
- Hospital density (Average square miles served per hospital): 1,632

Boundary Justification:

- This new HCC combines two HCCs into one.
- This HCC includes the Ute Mountain Ute and Southern Ute Indian Tribal Nations.
- Being the farthest HCC from the Denver Metropolitan area provides unique challenges for this region.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

Southwest Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	25,498
Population Impact: 1.76%	5,981
Total:	**$106,479**

Appendix F:

San Luis Valley Region (TBD) Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Alamosa:	16,008	722.64	1
▪ Conejos:	8,050	1,287.39	1
▪ Costilla:	3,578	1,226.95	0
▪ Mineral:	728	875.67	0
▪ Rio Grande:	11,475	911.96	1
▪ Saguache:	6,258	3,168.53	0
Total:	46,097	8,193.14	3

- Population density (Average number of people per square mile): 6
- Hospital density (Average number of people per hospital): 15,366
- Hospital density (Average square miles served per hospital): 2,731

Boundary Justification:

- This new HCC combines two HCCs into one.
- These communities generally work well together and share many of the same characteristics. These communities are self-sufficient, but also very willing to assist each other during times of need.
- This is generally a rural and frontier community with a low population density.
- This is largely an agricultural community.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	-	140,230
OEPR Administration: (15% ASPR Cap)	-	467,909
		608,139
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:		-321,000 (2016-17 amount)
CCHN:		-170,000 (2016-17 amount)
EM Systems:		-443,000 (2016-17 amount)
CVM:		-102,000 (2016-17 amount)
		1,036,000
Cash available to support HCCs:		1,475,253

San Luis Valley Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	21,197
Population Impact: 0.84%	2,869
Total:	**$99,066**

Appendix G:
South Region (TBD) HEALTHCARE COALITION

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Custer:	4,464	738.63	0
▪ Fremont:	46,559	1,533.07	1
▪ Huerfano:	6,474	1,591.00	1
▪ Las Animas:	14,038	4,772.67	1
▪ Pueblo:	163,348	2,386.10	2
Total:	234,883	11,021.47	5

- Population density (Average number of people per square mile): 21
- Hospital density (Average number of people per hospital): 46,977
- Hospital density (Average square miles served per hospital): 2,204

Boundary Justification:

- This existing HCC has been working and planning together for years and will continue to work together to ensure the south region is prepared to respond when called upon.
- This HCC has been working with the South Central HCC in cross-jurisdiction planning.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

South Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	32,165
Population Impact: 4.30%	14,621
Total:	**$121,786**

Appendix H:
Southeast Region (TBD) Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Baca:	3,596	2,554.97	1
▪ Bent:	5,841	1,512.86	0
▪ Crowley:	5,539	787.42	0
▪ Kiowa:	1,391	1,767.77	1
▪ Otero:	18,288	1,261.96	1
▪ Prowers:	11,893	1,638.40	1
Total:	46,548	9,523.38	4

- Population density (Average number of people per square mile): 5
- Hospital density (Average number of people per hospital): 11,637
- Hospital density (Average square miles served per hospital): 2,381

Boundary Justification:

- This new HCC combines four HCCs into one.
- This HCC is made up of mostly frontier communities which are mostly self-sufficient but willing to support each other during incidents.
- This area is mostly agricultural.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

Southeast Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	26,622
Population Impact: 0.85%	2,897
Total:	**$104,520**

Appendix I:
South Central Region Healthcare Coalition

Demographics:

Community Statistics: Population from State Demography Office – 2015 data. Land Area is in Square Miles from the U.S. Census Bureau Geography Division

	Population	Land Area	Hospitals
▪ Chaffee:	18,604	1,013.40	1
▪ El Paso:	677,022	2,126.80	2
▪ Lake:	7,483	376.91	1
▪ Park:	16,659	2,193.85	0
▪ Teller:	23,461	557.06	1
Total:	743,229	6,268.02	5

- Population density (Average number of people per square mile): 119
- Hospital density (Average number of people per hospital): 148,646
- Hospital density (Average square miles served per hospital): 1,254

Boundary Justification:

- This existing HCC is the only HCC in the state that is currently a formal non-profit corporation with IRS 501C3 status.
- These communities have worked well together in the past and have proven to be effective during large-scale emergencies in the past.
- These communities support a college campus, mountain recreational tourism, and military installations.

Fund Allocation:

Total HPP Grant:		3,119,392
CDPHE Indirect:	- 140,230	
OEPR Administration: (15% ASPR Cap)	- 467,909	
	608,139	
Funds to support HCCs:		2,511,253
Less Centrally Procured Services:		
CHA:	-321,000 (2016-17 amount)	
CCHN:	-170,000 (2016-17 amount)	
EM Systems:	-443,000 (2016-17 amount)	
CVM:	-102,000 (2016-17 amount)	
	1,036,000	
Cash available to support HCCs:		1,475,253

South Central Region HCC Allocation:	
Base Amount:	75,000
Regional Impact:	28,515
Population Impact: 13.62%	46,263
Total:	**$149,778**